STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	003776	A. BUILDING: _____ B. WING _____	03/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IU HEALTH WEST HOSPITAL	1111 N RONALD REAGAN PKWY AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This was for investigation of a State complaint. Complaint: #IN00136700 Unsubstantiated: Lack of sufficient evidence. Facility Number: 003776 Survey Date: 03/13/2014 Surveyor: Saundra Nolfi, RN Public Health Nurse Surveyor IU Health West Hospital is in compliance with 410 IAC 15-1.5-2, Infection Control and 410 IAC 15-1.5-6, Nursing Services, Hospital Licensure Rules. QA: claughlin 03/14/14	S 000		